World Trade Center National Responder Health Program
Medical Records Release Form

Patient Name (Please Print)	WTC Number	Date of Birth (mm/dd/yyyy)

I Authorize:

Name of Sending Person/Organization: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

To Release To:

Logistics Health Incorporated
Attn: Records Management Department
328 Front Street South
La Crosse, WI 54601
Phone: 877-498-2911
Fax: 608-793-2964

I request and authorize the release of my health information noted below: (Please check all that apply).

☐ All Healthcare Information
☐ Pharmacy Report(s) Date(s) _____
☐ Lab Report(s) Date(s) _____
☐ Other _____
☐ X-Ray Report(s) Date (s) _____

- I understand that I am entitled to receive a copy of this authorization.
- I understand that I may withdraw this authorization in writing at any time.
- Unless otherwise specified below. I understand that this authorization will expire 90 days from the request date. I request that this authorization expire on (specify date): _____.

_____ _____ _____
Signature Date Daytime Phone Number

_____ _____
If Not Signed by Patient - Legal Representative's Name
Legal Representative's Relationship to Patient